

South East London Primary & Secondary Care Gynaecology Guidelines

May 2026

Date for Review: Summer 2028

Introduction

Primary and secondary care guidelines to support the diagnosis and management of Gynecology conditions.

This guide has been produced utilising published guidance and in collaboration with clinical and non-clinical staff across the South East London (SEL) Gynaecology Network, South East London Integrated Care Board, South East London Primary Care representatives, South East London Cancer Alliance, South East London Integrated Medicines Optimisation Committee (IMOC), Women's and Girls Health Hub, and with input from other speciality colleagues where relevant.

All prescribing should be in line with the [SEL Joint Medicines Formulary](#).

It is intended to be a guide to assist Primary care colleagues in decision making and does not replace clinical judgement.

We encourage users of this document to seek advice from primary or secondary care colleagues when they are unsure, the later using established communication channels (e.g. Consultant Connect, e-RS Advice and Guidance).

Shortages of medicines are becoming a frequent issue that hinders patients getting access to their medicines in a timely manner. Please see the medicines supply tool, which can be accessed from the SPS website (linked here). The tool provides up to date information on medication shortages, and also includes advice on the prescribing of alternative products. Once supply resolves, patients should be transferred back to their original formulary option, following discussion with patients that original formulary option is appropriate.

Authors and Governance

These guidelines have been drawn up with input from a number of clinicians across South East London (SEL). Key authors include Christopher Lee (Consultant Obstetrician and Gynaecologist at PRUH, KCH & Clinical Lead for the SEL Gynaecology Network, Ritu Agarwal (GP & Primary Care Clinical lead for the SEL Gynaecology Network), Javid Muglu (Consultant Obstetrician and Gynaecologist & Former chair of the SEL Non-Admitted working group within the SEL Gynaecology Network), Usha Kumar (Consultant in Sexual Reproductive Health, KCH), Annabel Sowemimo (Consultant Community and Sexual Reproductive Health, LGT) and a number of other clinical specialists across SEL with extensive consultation across primary, secondary and community health, including the Women and Girl's Health Hub programme across SEL

The guidelines were reviewed and signed off in SEL General Surgery workstream meetings and by the SEL Network Board.

Medicines and prescribing recommendations made within these guidelines have been reviewed and approved by the SEL Integrated Medicines Optimisation Committee (IMOC).

Guidelines have also been circulated to LMC representatives, Planned Care Leads in each borough, SEL Cancer Alliance, SEL GP Cancer Leads, SEL APC Ultrasound Modality Group and all SELGP's via the bulletin for review and comment. The guidelines have also been reviewed by the Divisional Governance Committee in each trust as required.

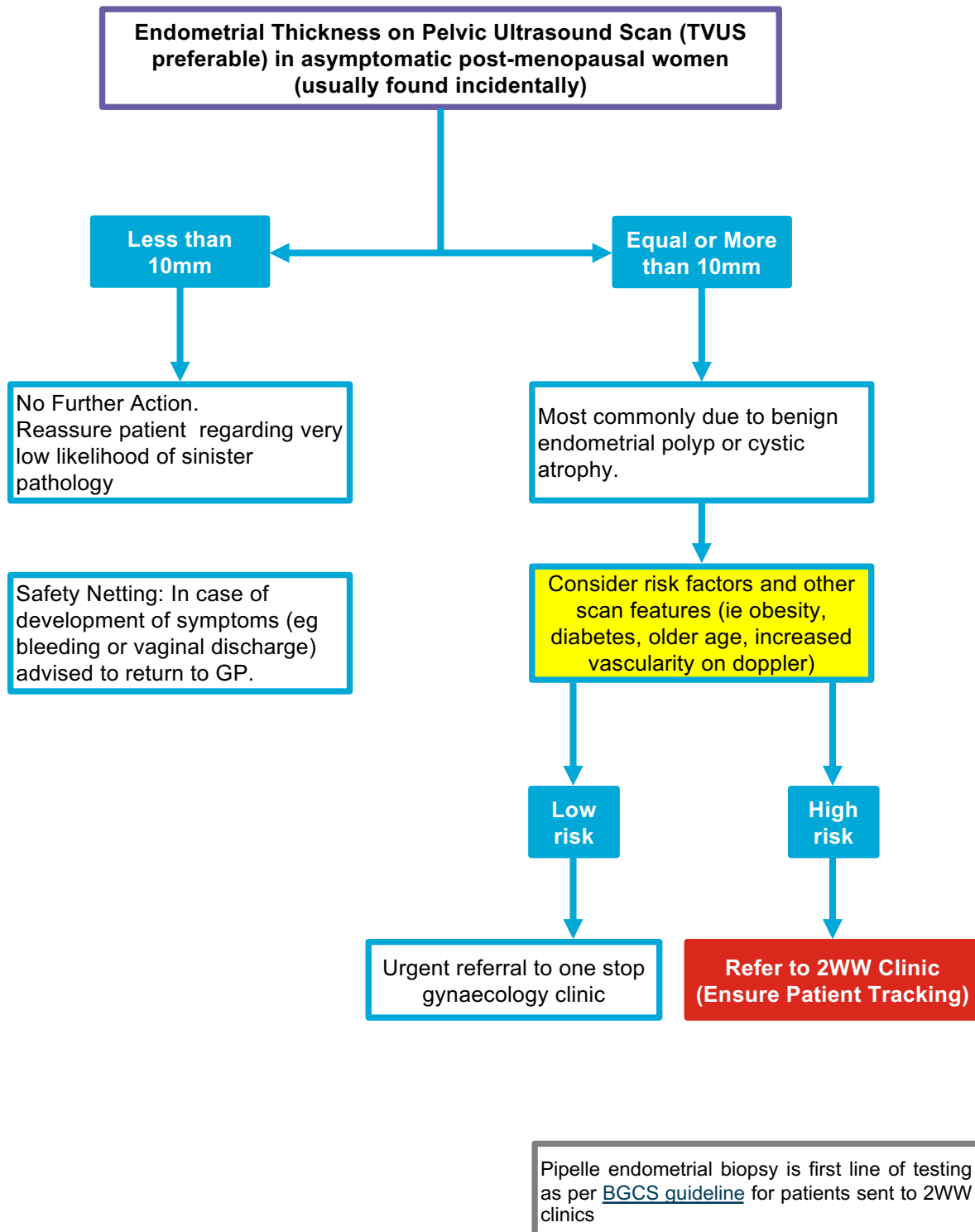
Version	Date signed off	Date of next review
1	May 2026	Summer 2028

Table of Contents

No.	Guideline
1	<u>Asymptomatic Increased in Endometrial Thickness in Post-Menopausal Women</u>
2	<u>Persistent Vaginal Discharge</u>
3	<u>Dysmenorrhoea</u>
4	<u>Inter-Menstrual Bleeding (Recurrent)</u>
5	<u>Cervical Polyps</u>
6	<u>Lichen Sclerosus</u>
7	<u>Recurrent First Trimester Miscarriage and one or more second trimester miscarriage</u>
8	<u>Heavy Menstrual Bleeding</u>
9	<u>Post-Coital Bleeding (Isolated)</u>
10	<u>Chronic Pelvic Pain</u>
11	<u>Management of Lost IUD</u>
12	<u>Oligomenorrhoea and Secondary Amenorrhoea</u>
13	<u>Suspected Polycystic Ovarian Syndrome (PCOS)</u>
14	<u>Post-Menopausal Ovarian Cyst</u>
15	<u>Pre-Menopausal Ovarian Cyst</u>
16	<u>Primary Amenorrhoea</u>
17	<u>Subfertility</u>
18	<u>Vulval Symptoms</u>
19	<u>Endometriosis</u>
20	<u>Guidelines for Management of Premenstrual Syndrome (PMS)</u>
21	<u>Premature Ovarian Insufficiency</u>
22	<u>Management of Pelvic Inflammatory Disease</u>
23	<u>Glossary</u>

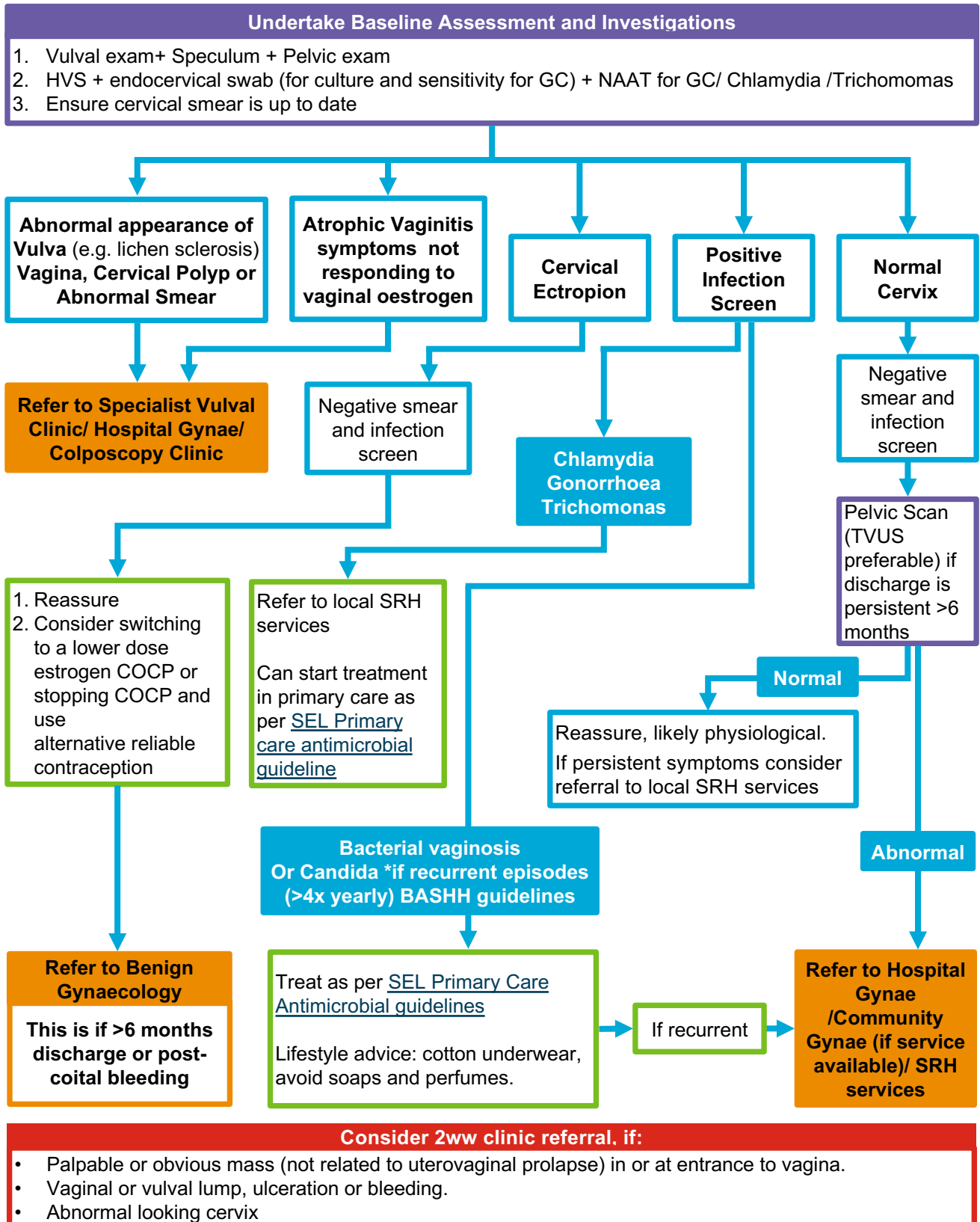
01. Asymptomatic Thickened Endometrium in Post-Menopausal Women

Management of incidentally increased Endometrial thickness on scan in post-menopausal women



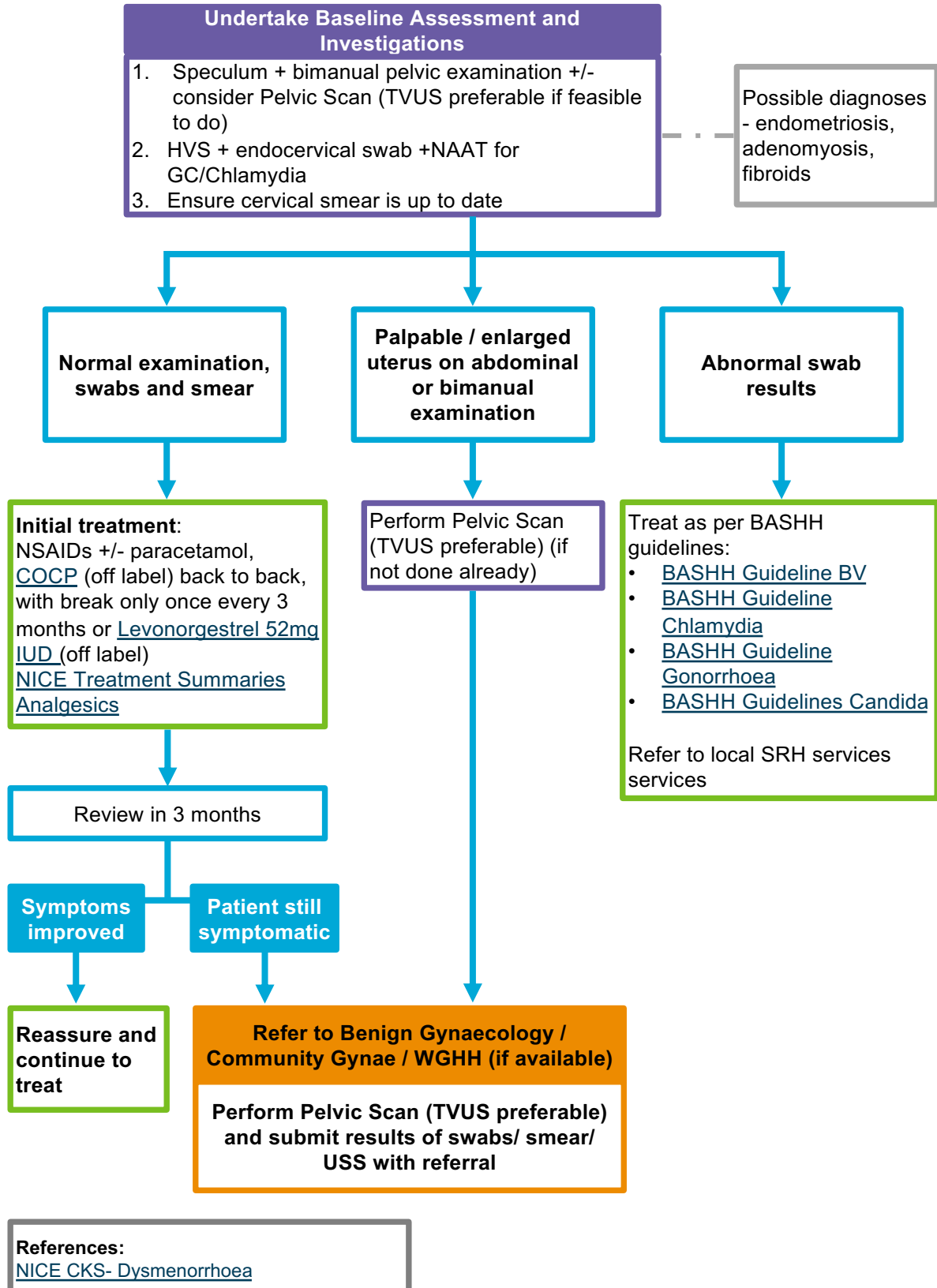
02. Persistent Vaginal Discharge

NICE CKS: Vaginal discharge



03. Dysmenorrhoea

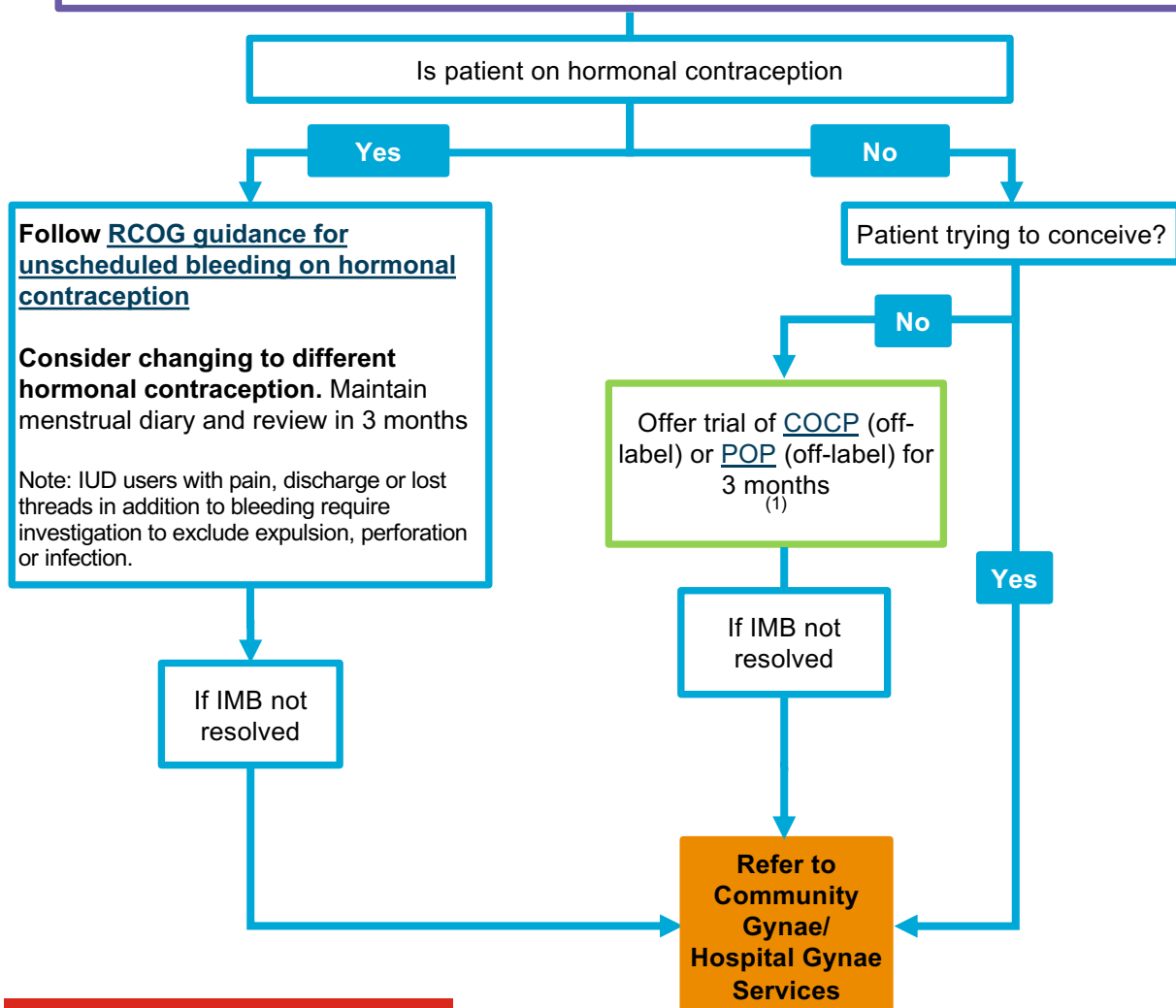
NICE CKS: Dysmenorrhoea



04. Inter-Menstrual Bleeding (Recurrent) and Break Through Bleeding

Undertake Baseline Assessment and Investigations

1. Speculum + pelvic exam +/- Pelvic Scan (TVUS preferable, scan recommended for all women over 40)
2. HVS + endocervical swab +NAAT for GC/Chlamydia. If abnormal Treat as per BASHH guidelines: www.bashh.org/guidelines
3. Ensure cervical smear is up to date
4. Pregnancy test (only in reproductive age group): if positive refer to early pregnancy unit



Consider 2ww clinic referral if:

- Suspicious findings on history, clinical examination or ultrasound

Link to the formulary for COCP -

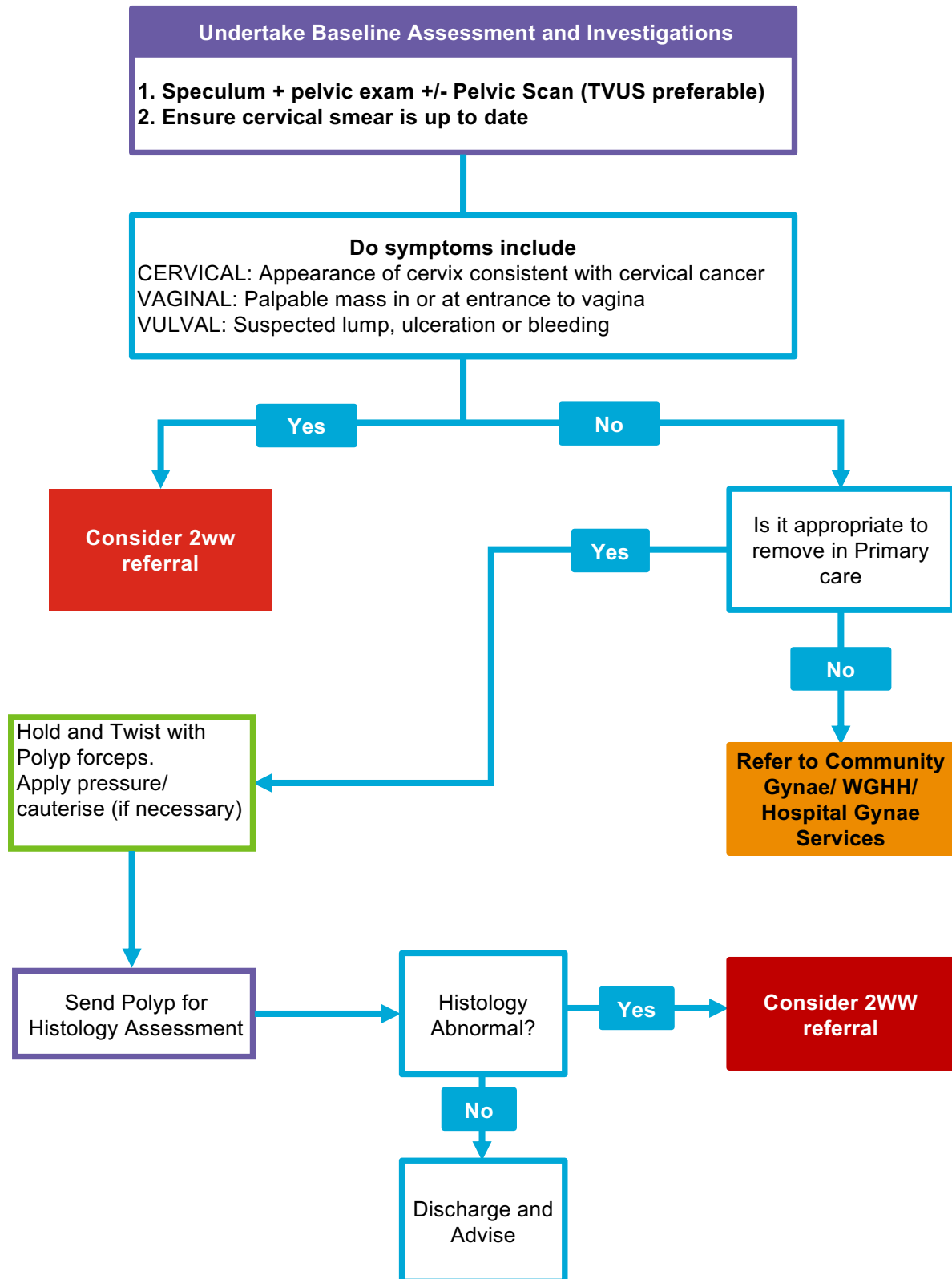
<https://www.selondonjointmedicinesformulary.nhs.uk/chaptersSubDetails.asp?FormularySectionID=7&SubSectionRef=07.03.01&SubSectionID=A100>

Note (1): If patients' preference is to be referred to secondary care for investigation rather than taking hormonal treatment, this is acceptable also.

References:

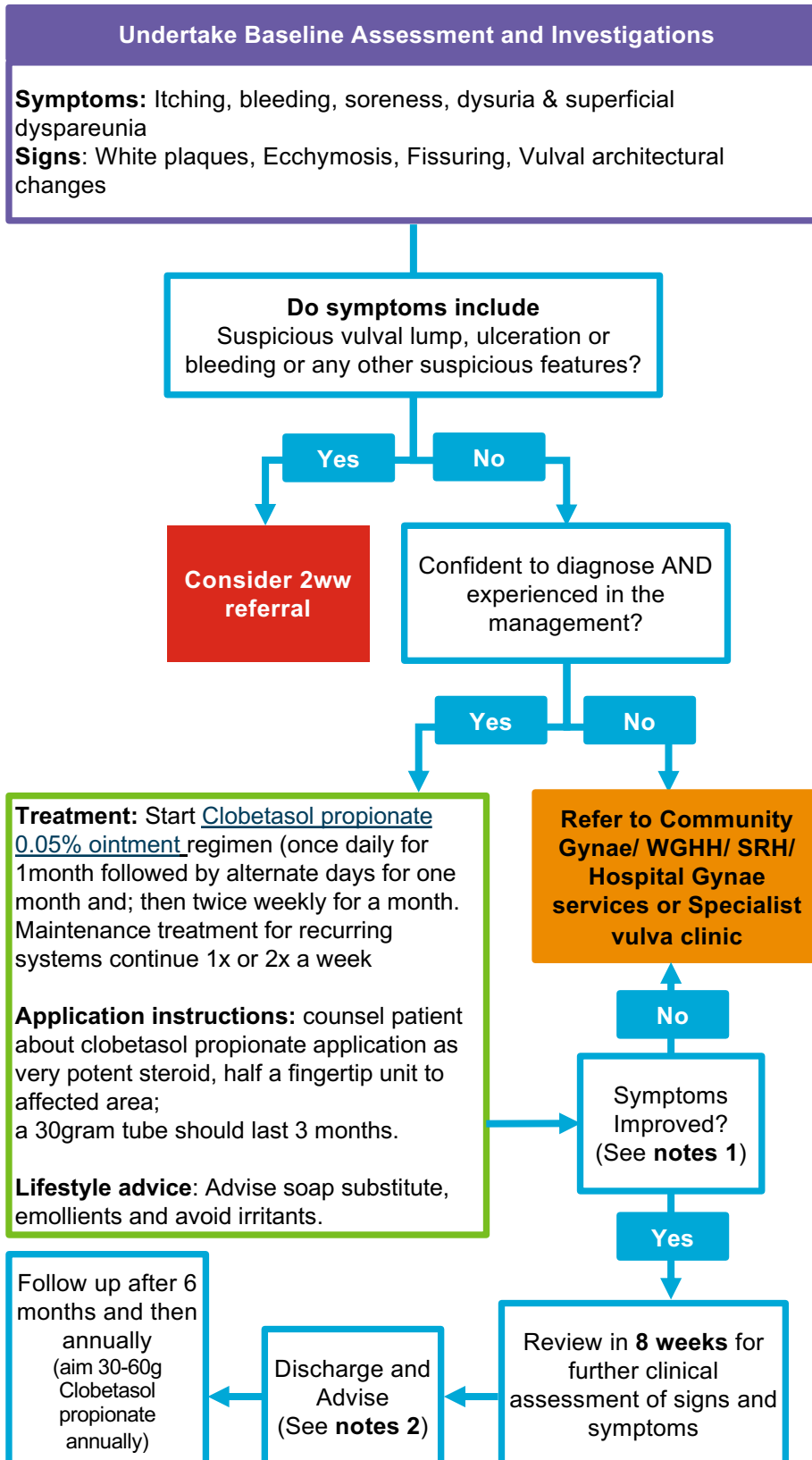
<https://www.rcog.org.uk/globalassets/documents/guidelines/unscheduledbleeding23092009.pdf>

05. Cervical Polyps



06. Lichen Sclerosus

Management Pathway for Adult Female Lichen Sclerosus



Notes:

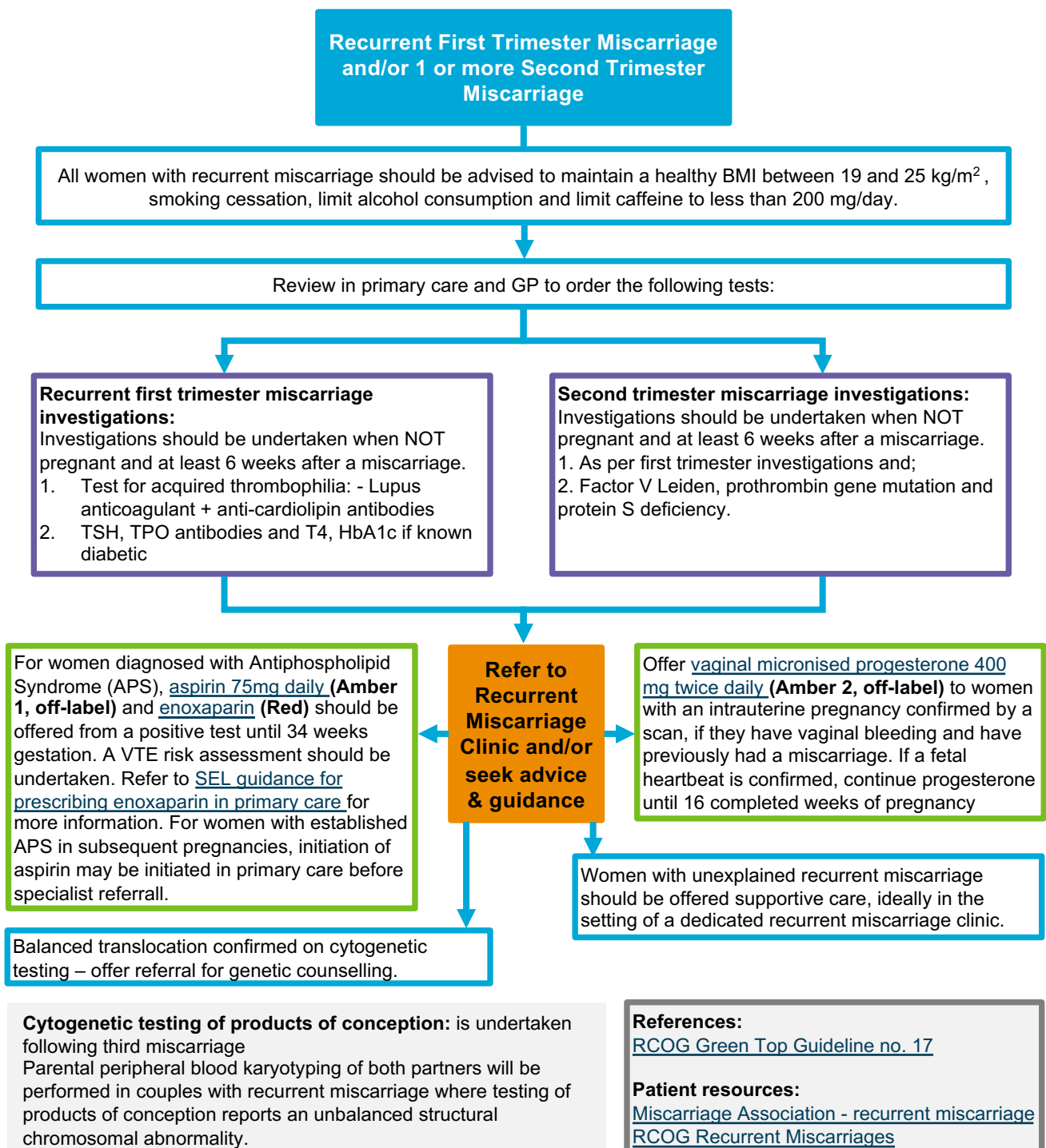
- (1) **Symptom Improvement:** Good Symptom Control, no active disease, no further alteration of architecture. Advise to use topical steroid long-term as needed for recurrence (use same regime as initial treatment) and continue emollients.
- (2) **Discharge and advise**
Topical steroids as needed Self-examination every 6-12 months and to seek medical advice in case of non-healing ulcers, lump or persistence of recurrent symptoms even after 3-4 weeks of daily steroids regime. If symptoms recur or above issues refer to the secondary care gynaecology service. Current ISSVD recommends monthly self-checks with LS and primary care continue to long term steroids.

[British Association of Dermatologists guidelines for the management of lichen sclerosis](#)

[Patient info - ISSVD Vulvar Lichen Sclerosus](#)
[Patient info - British Association of Dermatologists \(BAD\) Lichen Sclerosus](#)

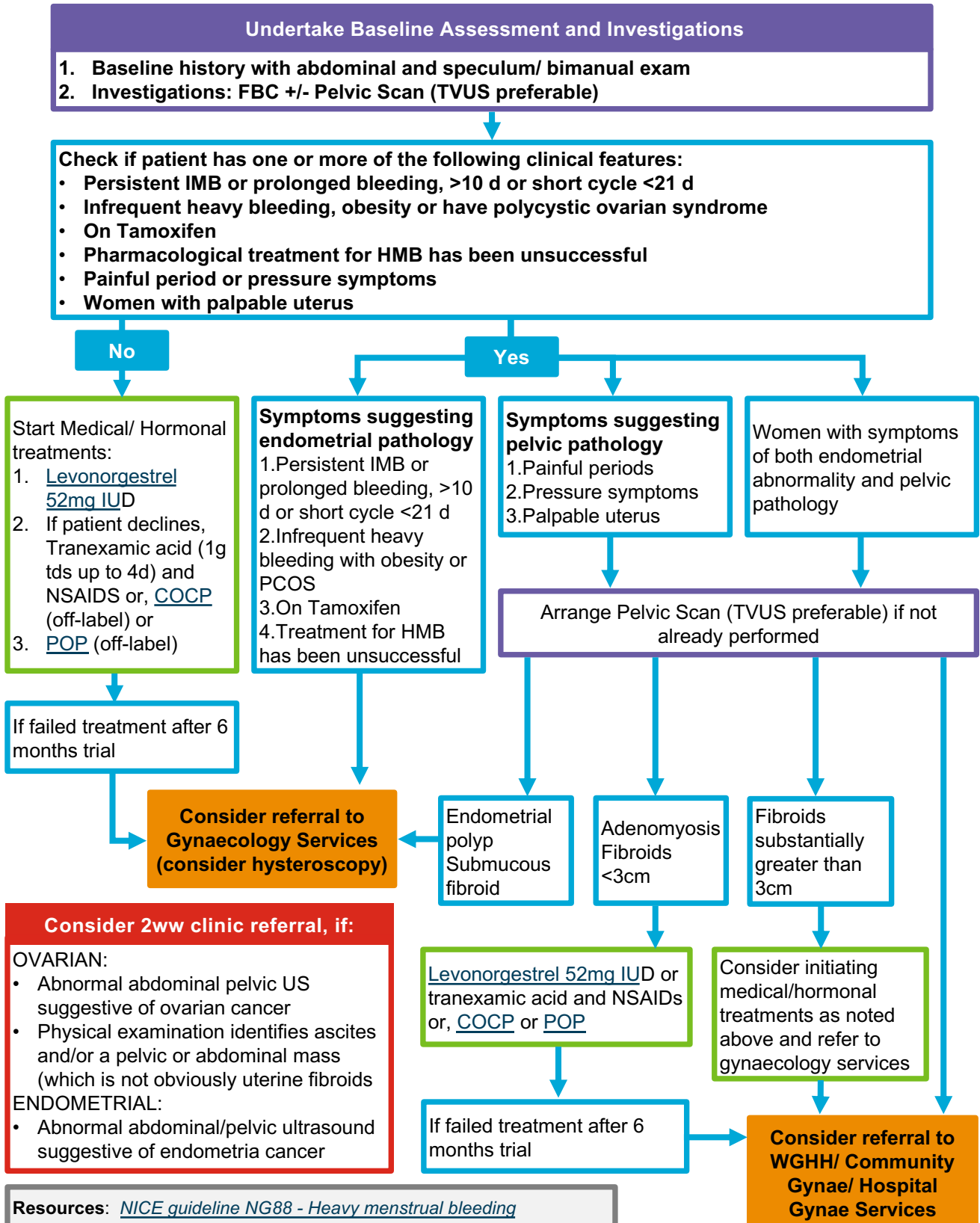
07. Recurrent First Trimester Miscarriage and/or one or more second trimester miscarriage

(Recurrent first trimester miscarriage is classified as ≥ 3 first trimester [<13 weeks] miscarriage). However, clinicians are encouraged to use their clinical discretion to recommend evaluation after two first trimester miscarriages, if there is a suspicion that the miscarriages are of pathological and not of sporadic nature.



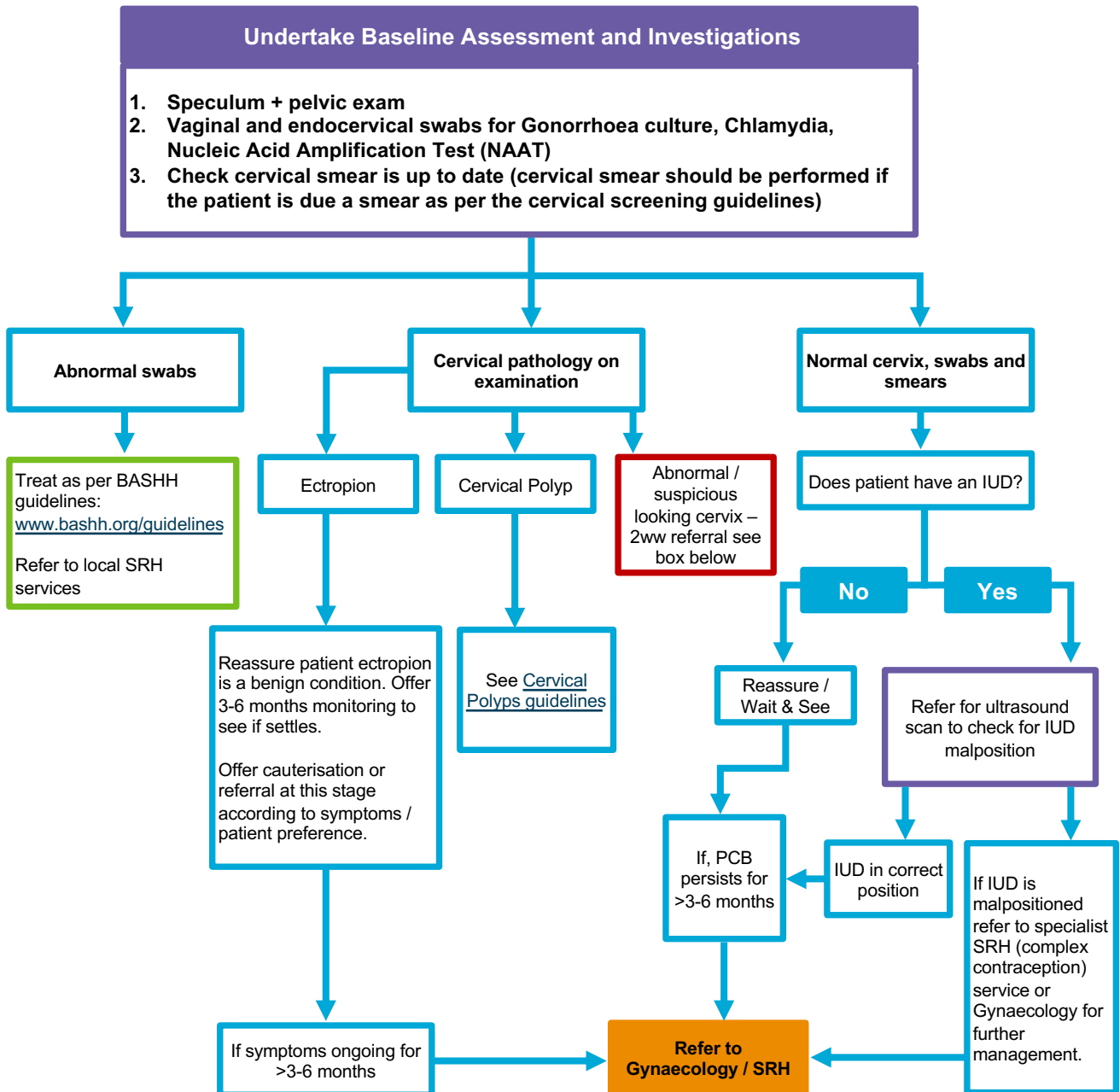
08. Heavy Menstrual Bleeding

NICE CKS: Menorrhagia



09. Post-coital bleeding

[for PCB associated with IMB, follow the IMB guidelines]

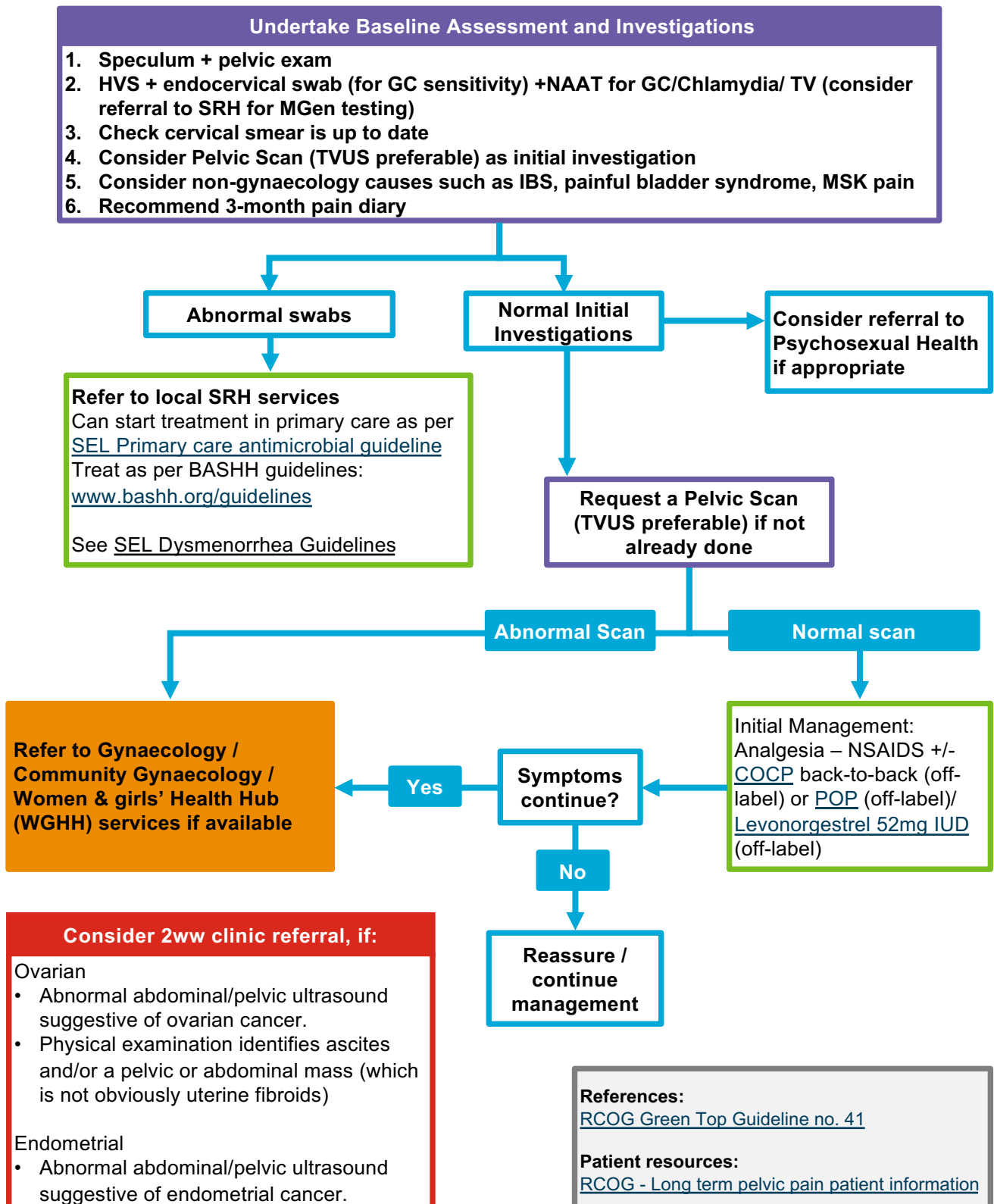


Consider 2ww clinic referral, if:

- Abnormal / suspicious looking cervix
- Unexplained palpable mass in or at entrance to vagina
- Unexplained lump, ulceration or bleeding

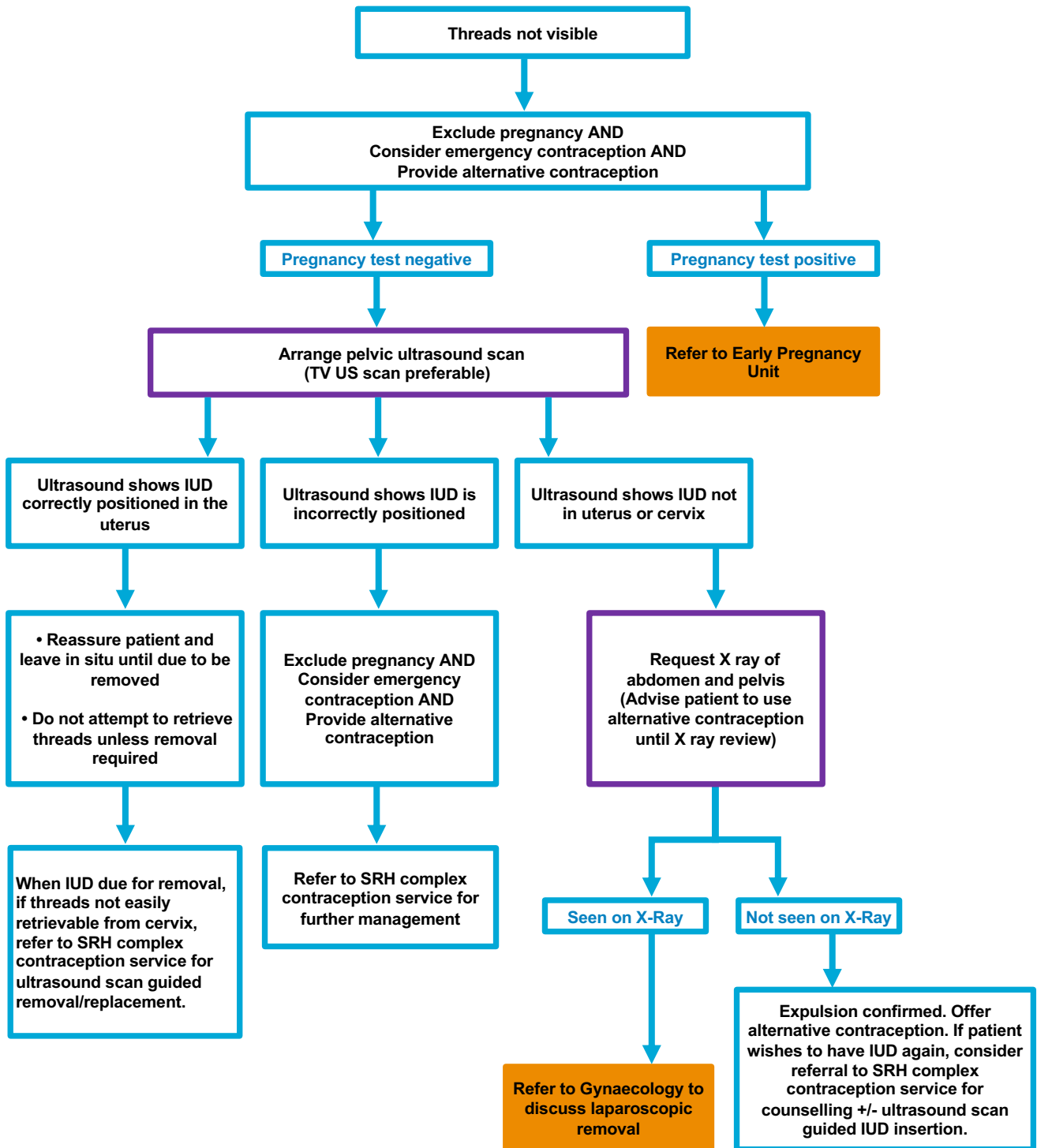
10. Chronic Pelvic Pain

(Over 6 months of cyclical or constant pelvic pain in pre-menopausal women)



11. Management of Lost IUD

Management of individuals when intrauterine contraceptive device (IUD) threads are not visible on speculum examination.



12. Management of Oligomenorrhoea

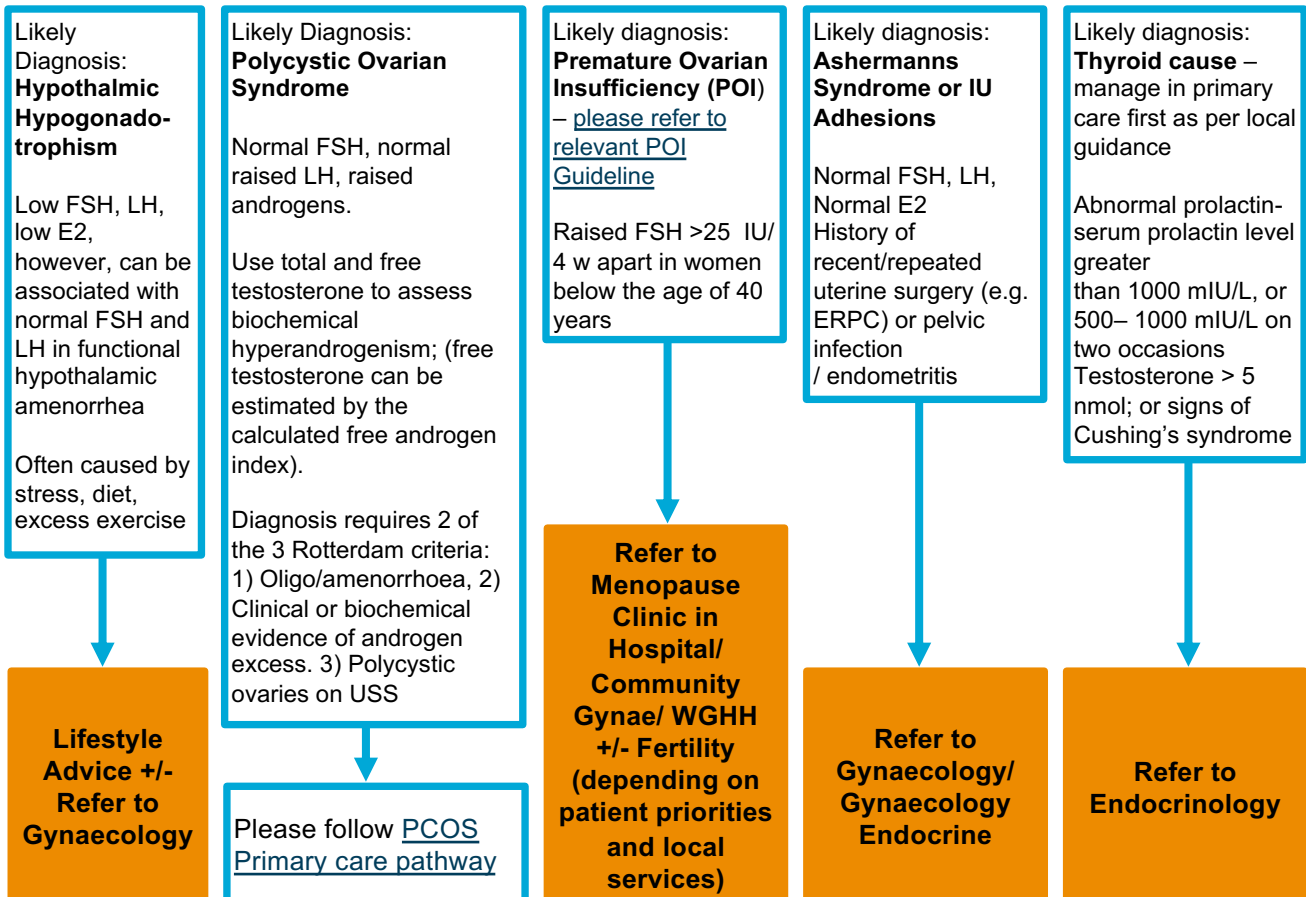
(Menses >35 Days Apart For 4 Or More Months) And Secondary Amenorrhoea

NICE CKS: [Secondary amenorrhea](#)

(Cessation of menstruation for 3 months in women with previously normal and regular menses or for 6 months in women with previous oligomenorrhoea)

Baseline Assessment

1. History of menses, diet and exercise, symptoms or signs of androgen excess, risk factors for premature ovarian insufficiency (radiotherapy, chemotherapy, autoimmune disease), chronic medical conditions, gynaecology surgical history and drug history
2. Examination: BMI, abdominal and pelvic examination, signs of androgen excess/virilisation or thyroid dysfunction
3. Pelvic Scan (TVUS preferable)
4. Blood serology: thyroid function tests, prolactin, FSH, LH, total testosterone, serum estradiol
5. Pregnancy test (if appropriate).



Reference: [NICE CKS - Amenorrhoea Guidance](#)

Note: It is very difficult to reliably assess for biochemical hyperandrogenism in women on the COCP. Consider withdrawing the pill for a minimum of 3 months (using alternative contraception as appropriate), in patients already on COCP in whom androgen quantification is imperative ([International Evidence-based Guideline for the assessment and management of PCOS 2023](#)).

13. Suspected Polycystic Ovarian Syndrome (PCOS)

(Features of oligo/amenorrhoea, polycystic ovaries on ultrasound, signs of hyperandrogenism or subfertility)

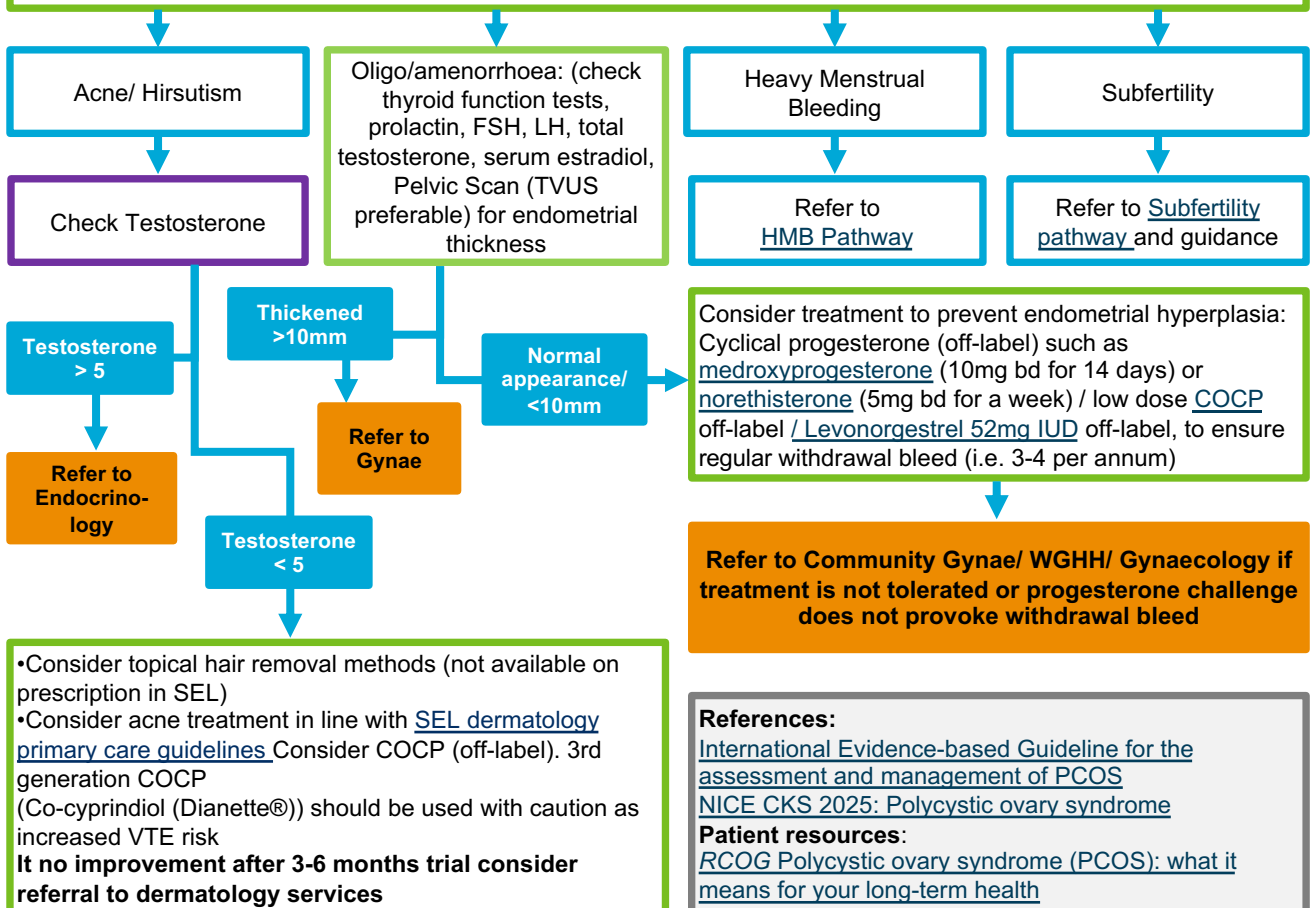
NICE CKS: [Polycystic ovary syndrome](#)

Baseline Assessment for Diagnosing PCOS: Two or more of the following three Rotterdam criteria must be present

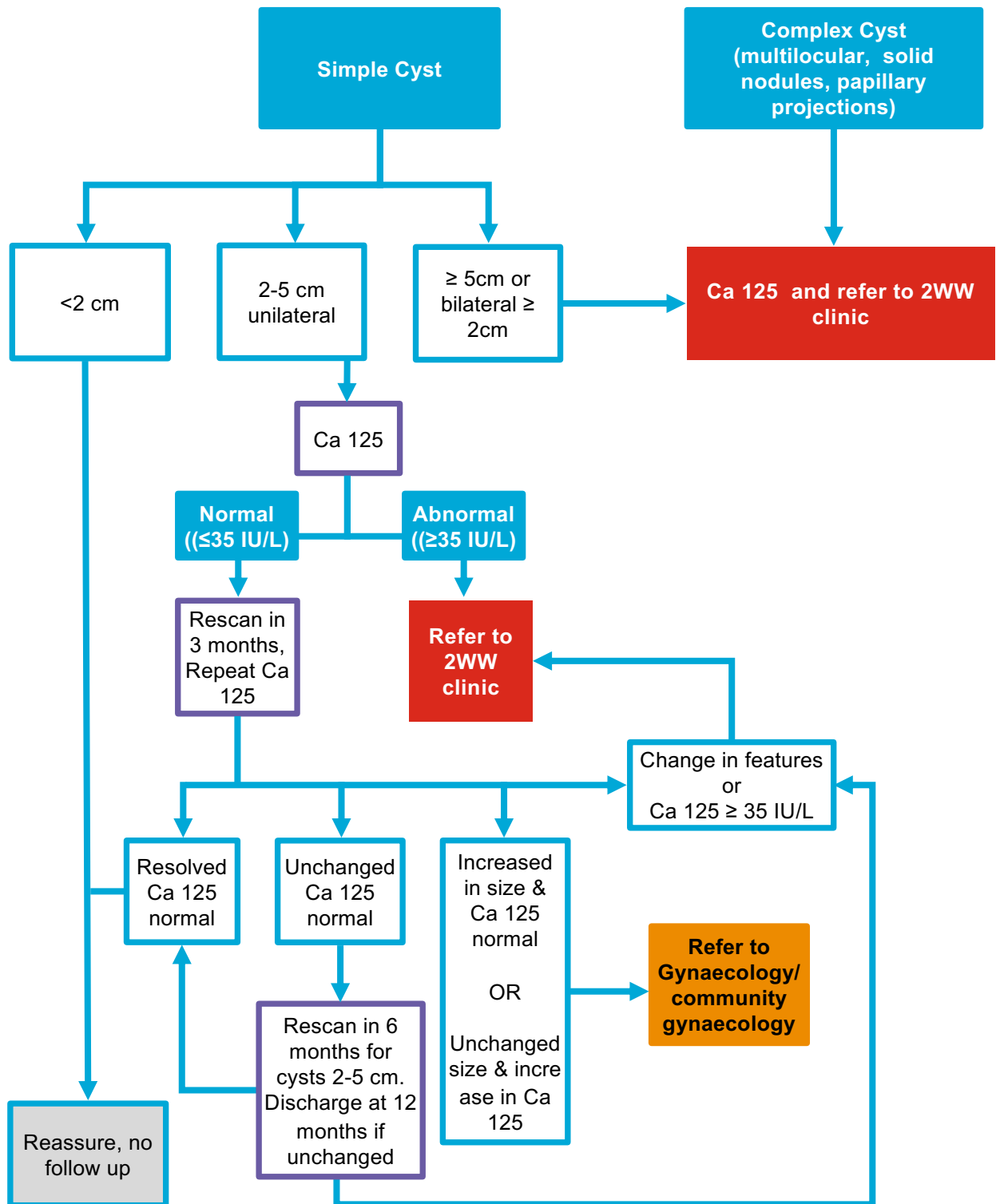
1. Infrequent or no ovulation (oligomenorrhoea = cycle length >35 days or amenorrhoea for 6m or more).
2. Clinical and/or biochemical signs of hyperandrogenism (such as hirsutism, acne, or elevated levels of total or free testosterone).
3. Polycystic Ovarian Morphology (PCOM) on ultrasound scan. Menstrual cycles are often irregular during 1st few years after menarche and do not need investigating generally. Ultrasound scan is no longer recommended in the diagnosis of PCOS in those within 8 years of menarche due to the high incidence of multi-follicular ovaries in this life stage (NICE 2025).

Management for ALL Patients with PCOS:

1. Initial lifestyle measures: modify cardiovascular risks, healthy low glycaemic index diet and exercise, if BMI>25 check HbA1c
2. Management of each clinical problem as described below
3. Counselling, support and primary care follow up for long-term Consequences of PCOS
4. In addition to lifestyle measures, [metformin](#) (off-label, Amber 1) can be considered after seeking specialist advice, in women with a BMI of >25kg/m² for the management of weight and metabolic outcomes. Seek specialist advice before initiating metformin for women without diabetes in primary care. (NICE CKS 2025).

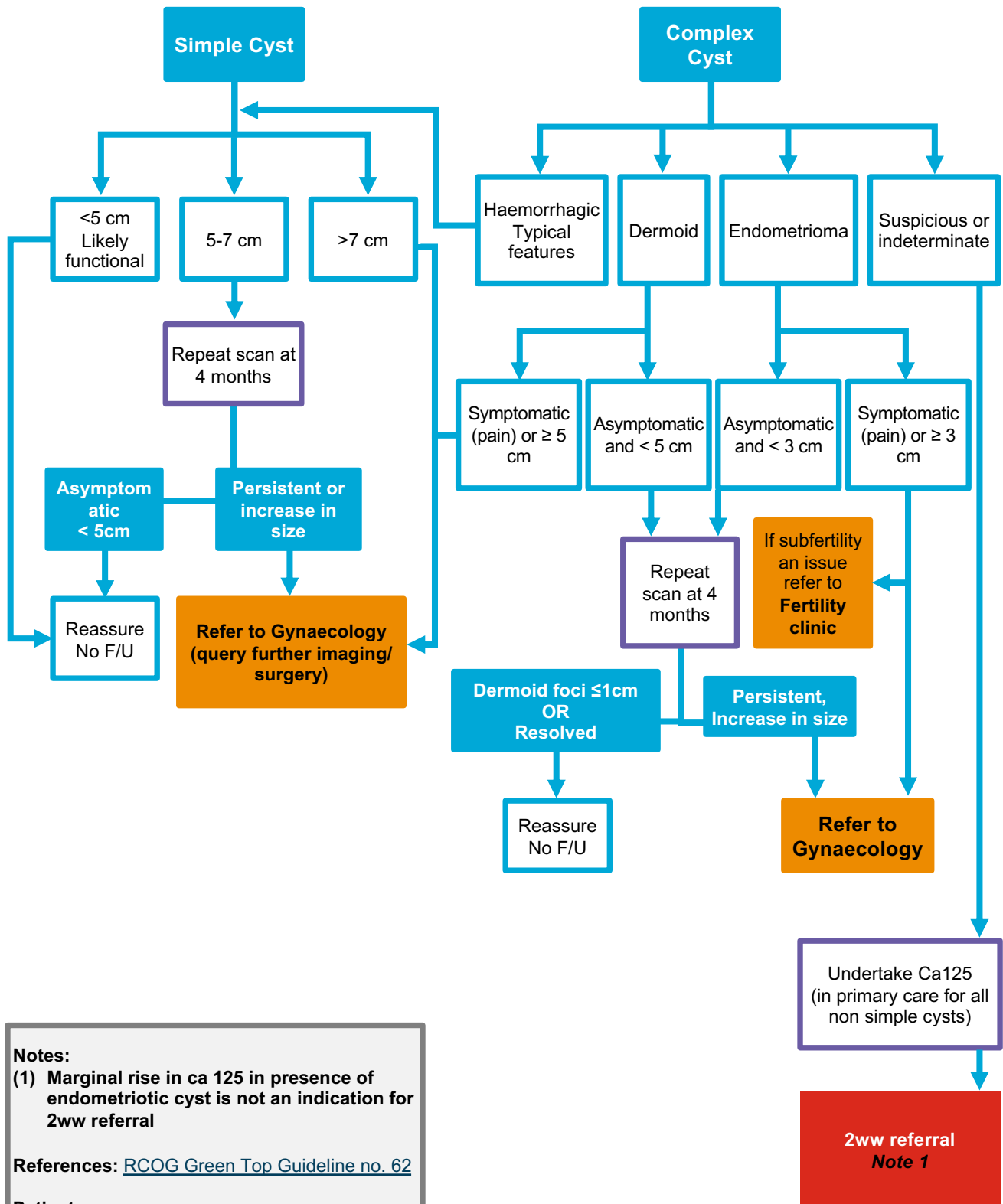


14. Post-Menopausal Ovarian Cyst



References: [RCOG Green Top Guideline no. 34](#)

15. Pre-Menopausal Ovarian Cyst



Notes:

(1) Marginal rise in ca 125 in presence of endometriotic cyst is not an indication for 2ww referral

References: [RCOG Green Top Guideline no. 62](#)

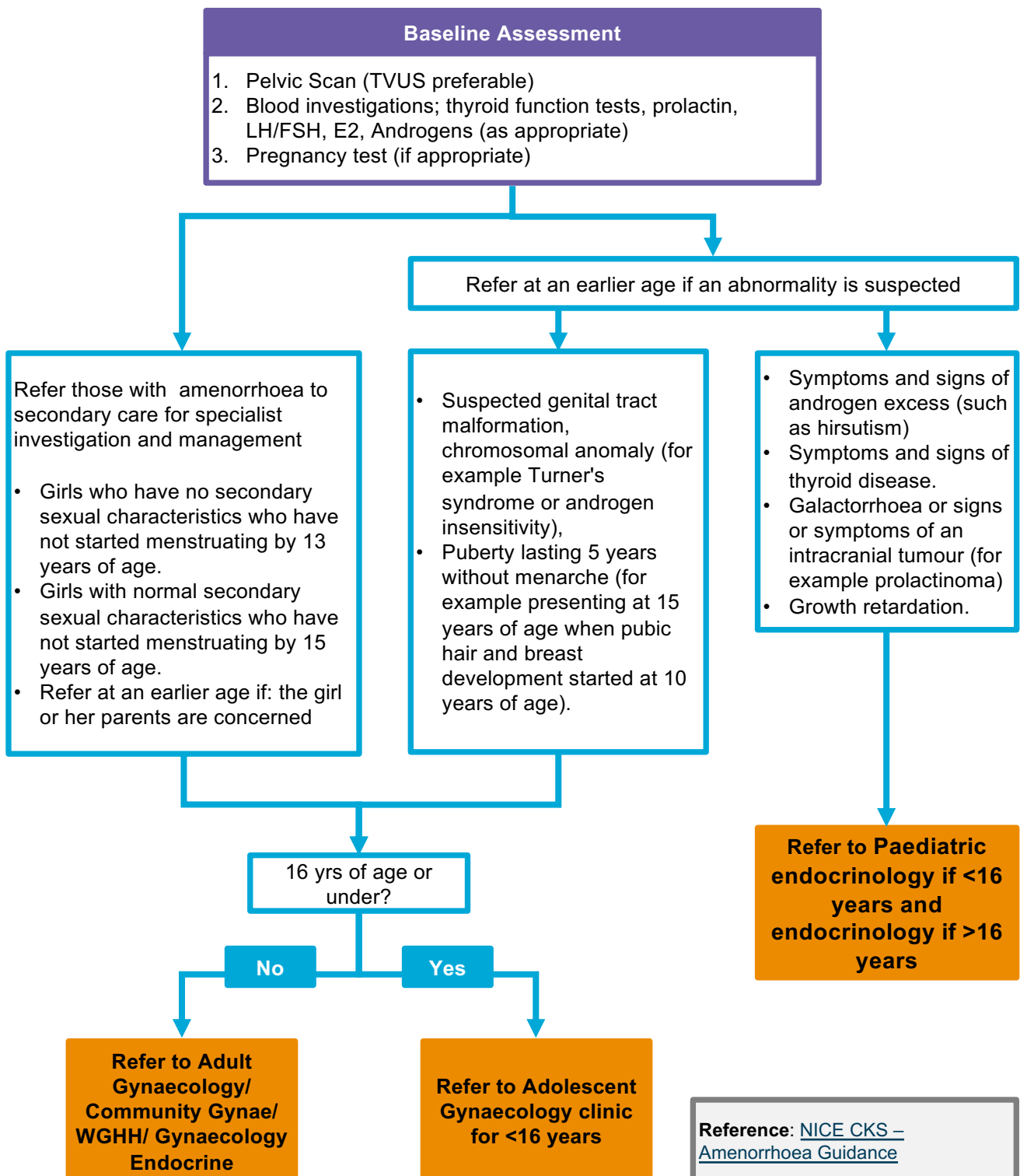
Patient resources:

[Ovarian cysts before the menopause | RCOG](#)

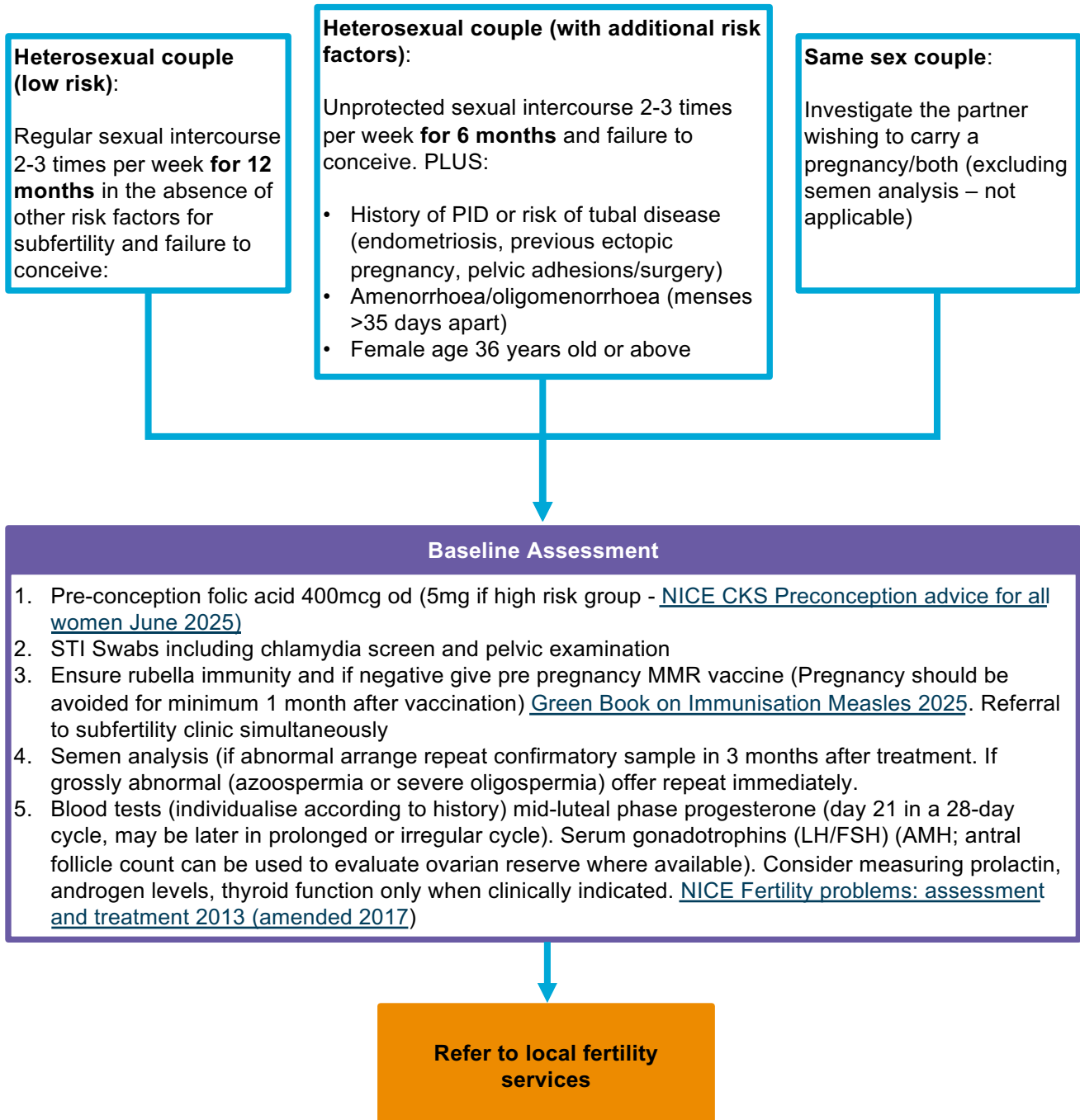
16. Primary Amenorrhoea

NICE CKS: Primary amenorrhoea

(Primary amenorrhoea is the failure to establish menstruation by the time of expected menarche)



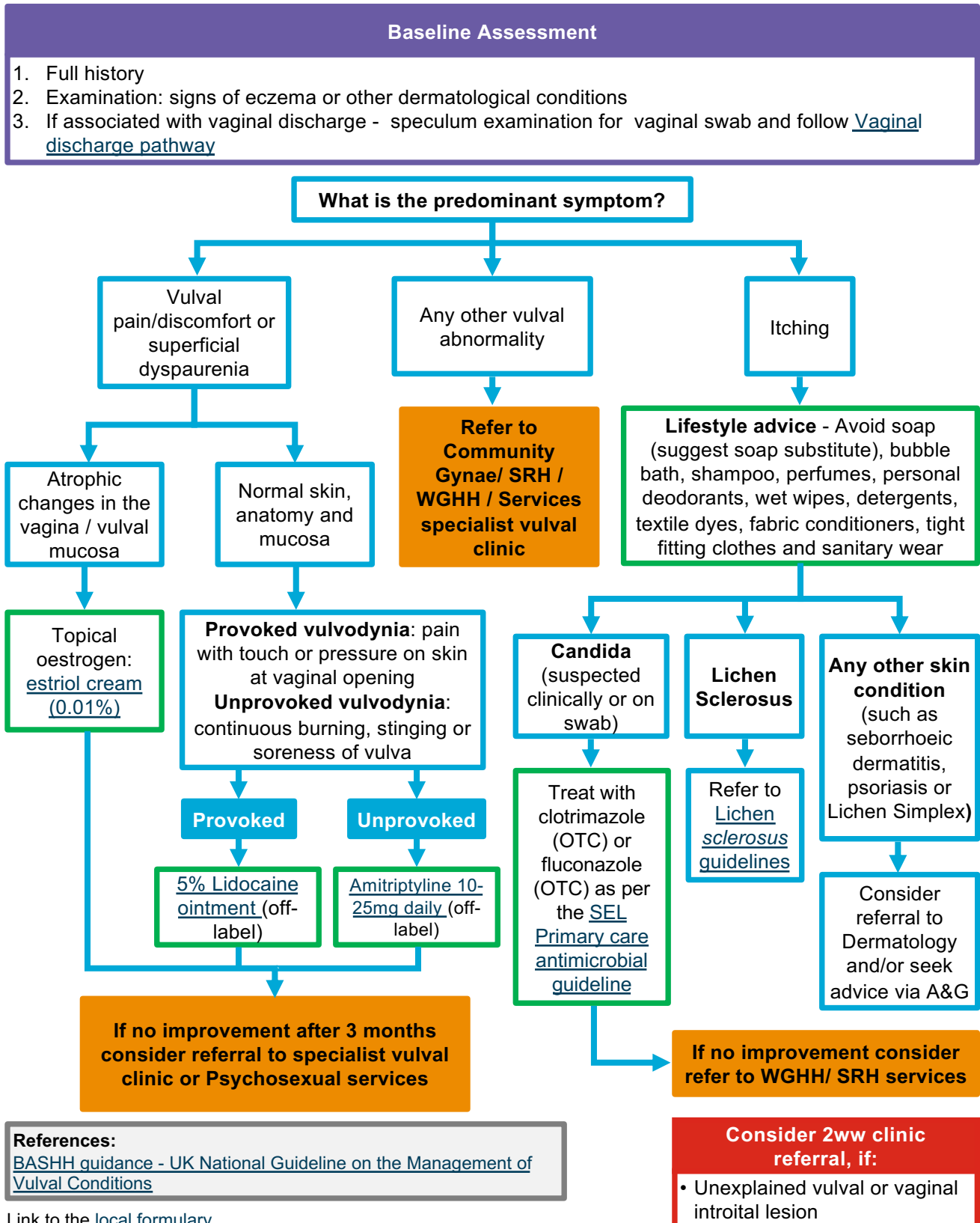
17. Subfertility



References:

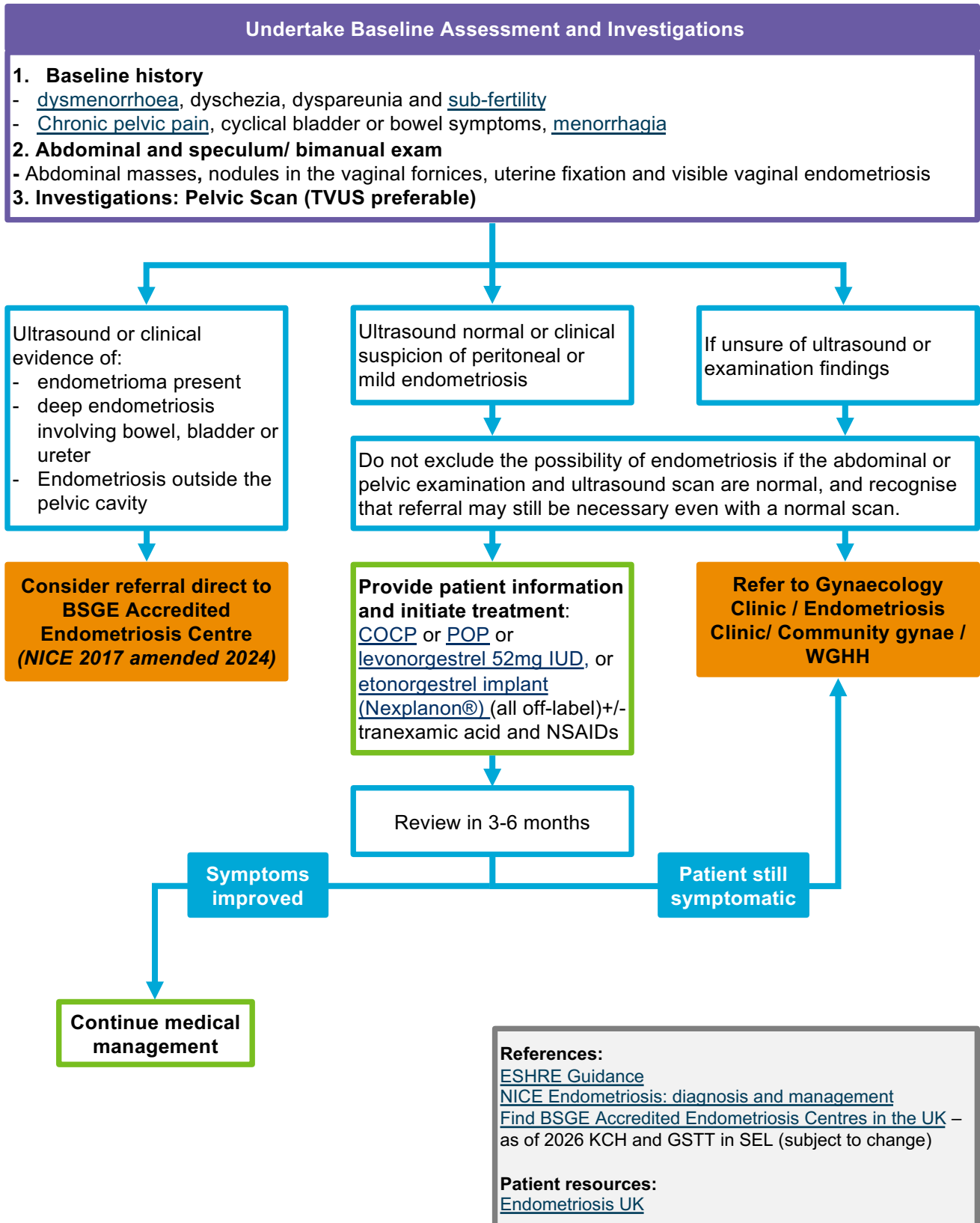
[NICE Fertility problems: assessment and treatment 2013 \(amended 2017\)](#)
[SEL Fertility Treatment and Preservation Policy 2024](#)
[Patient Info Infertility Leaflet – Patient Information](#)

18. Vulval symptoms



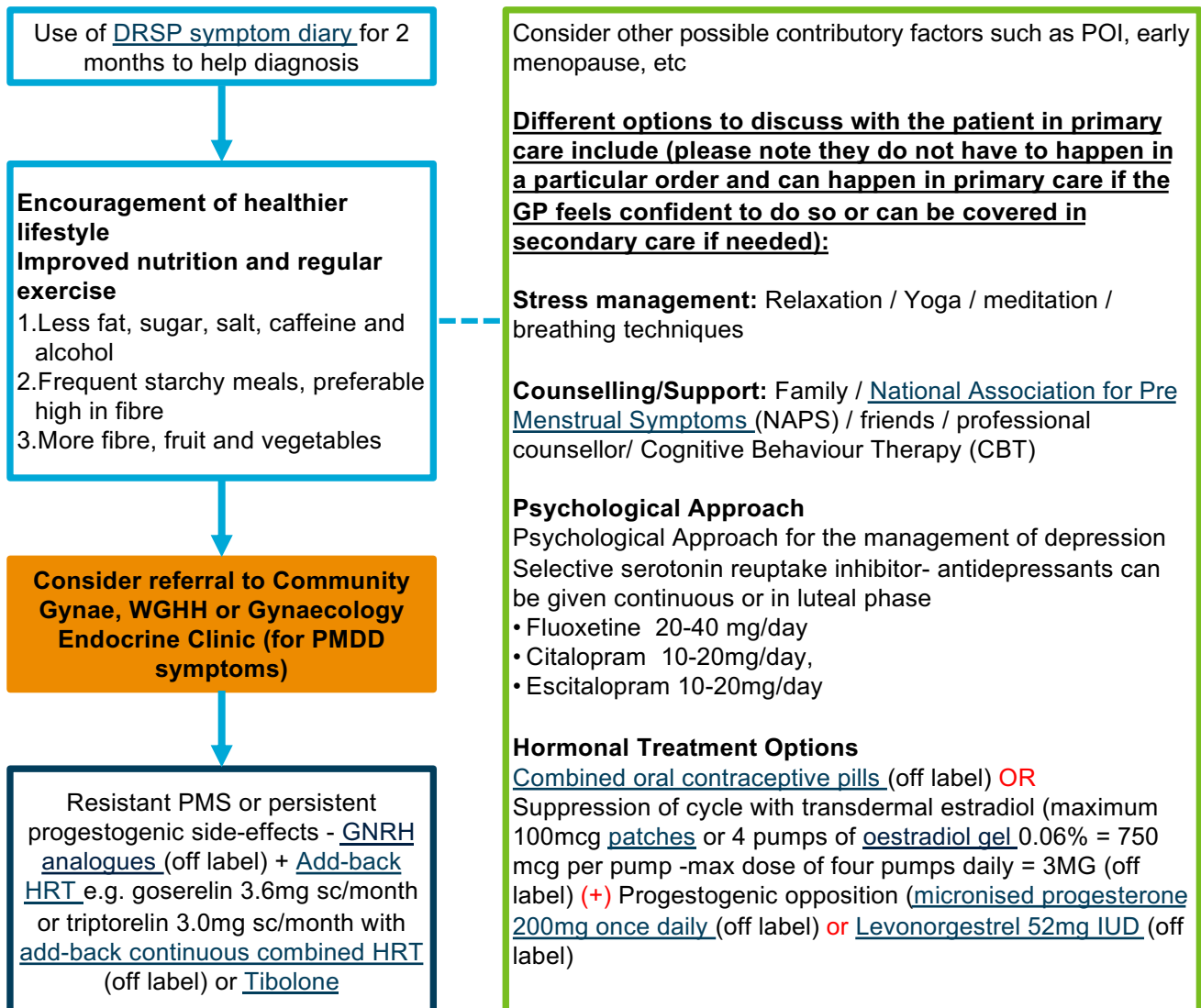
19. Endometriosis

NICE CKS: Endometriosis



20. Management of Premenstrual Syndrome (PMS) / Premenstrual dysphoric disorder (PMDD)

NICE CKS: Premenstrual syndrome



Refer as and when needed to secondary care

Severe PMS sometimes improves with treatments from the first two levels, but may require more aggressive forms of management sooner rather than later

References:

RCOG Green Top Guideline no. 48
NAPS Guidelines on PMS

Patient resources:

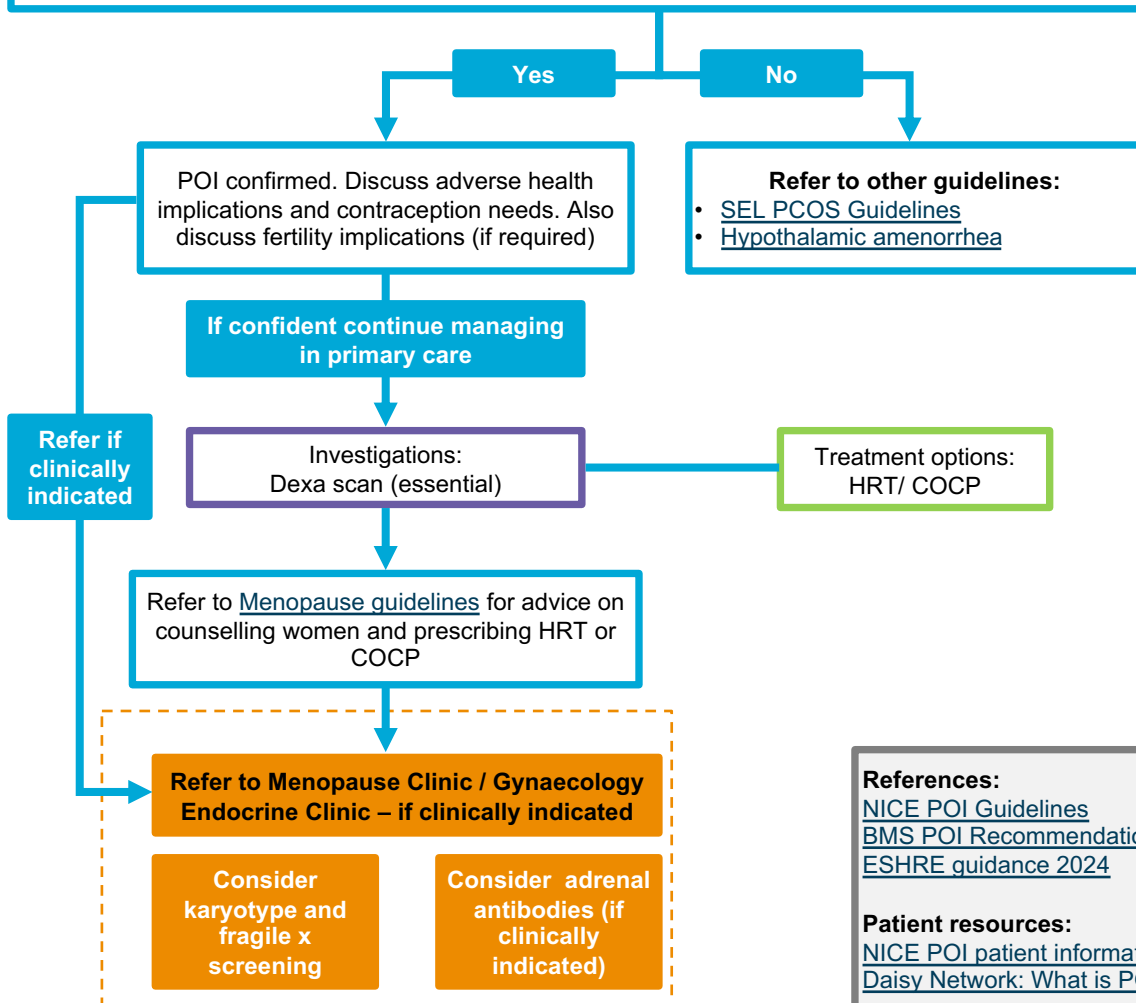
RCOG patient information PMS

21. Suspected Premature Ovarian Insufficiency (POI)

Undertake Baseline Assessment and Investigations for Amenorrhoea or Oligomenorrhoea (including POI, PCOS)

1. History -including menstrual and sexual history, risk factors for premature ovarian insufficiency (radiotherapy, chemotherapy, autoimmune disease), chronic medical conditions, and drug history
2. Examination – BMI (height and weight), blood pressure, breast examination (if history of galactorrhoea), dysmorphic features (chromosomal or genetic); Skin (hirsutism, acne, striae, acanthosis nigricans and vitiligo)
3. Pelvic Scan (TVUS preferable)
4. Blood serology: TFT, FSH, LH and oestradiol levels, serum prolactin
5. Pregnancy test (if appropriate)
6. Exclude for other causes of amenorrhoea (for example [PCOS](#), [hypothalamic amenorrhoea](#))
7. Use of hormonal therapy (including oral, injectable, or long-acting contraceptives) may conceal or cause amenorrhoea or irregular menstrual cycles, and potentially lower FSH concentrations. Some hormonal therapy (e.g., combined oral contraceptive) may need to be ceased before a diagnosis of POI can be confirmed. - Women who had Bilateral Salpingo-Oophorectomy (BSO) before age 40 have a diagnosis of POI and additional diagnostic testing is unnecessary.

FSH levels of ≥ 25 IU/L. FSH testing for the diagnosis of POI does not have to be timed to a specific day of the menstrual cycle. Repeat test if there is diagnostic uncertainty with first test- to be measured 4-6 weeks apart in women <40 years old (i.e. 1st FSH level >25 no need for a repeat test to confirm POI diagnosis)



References:

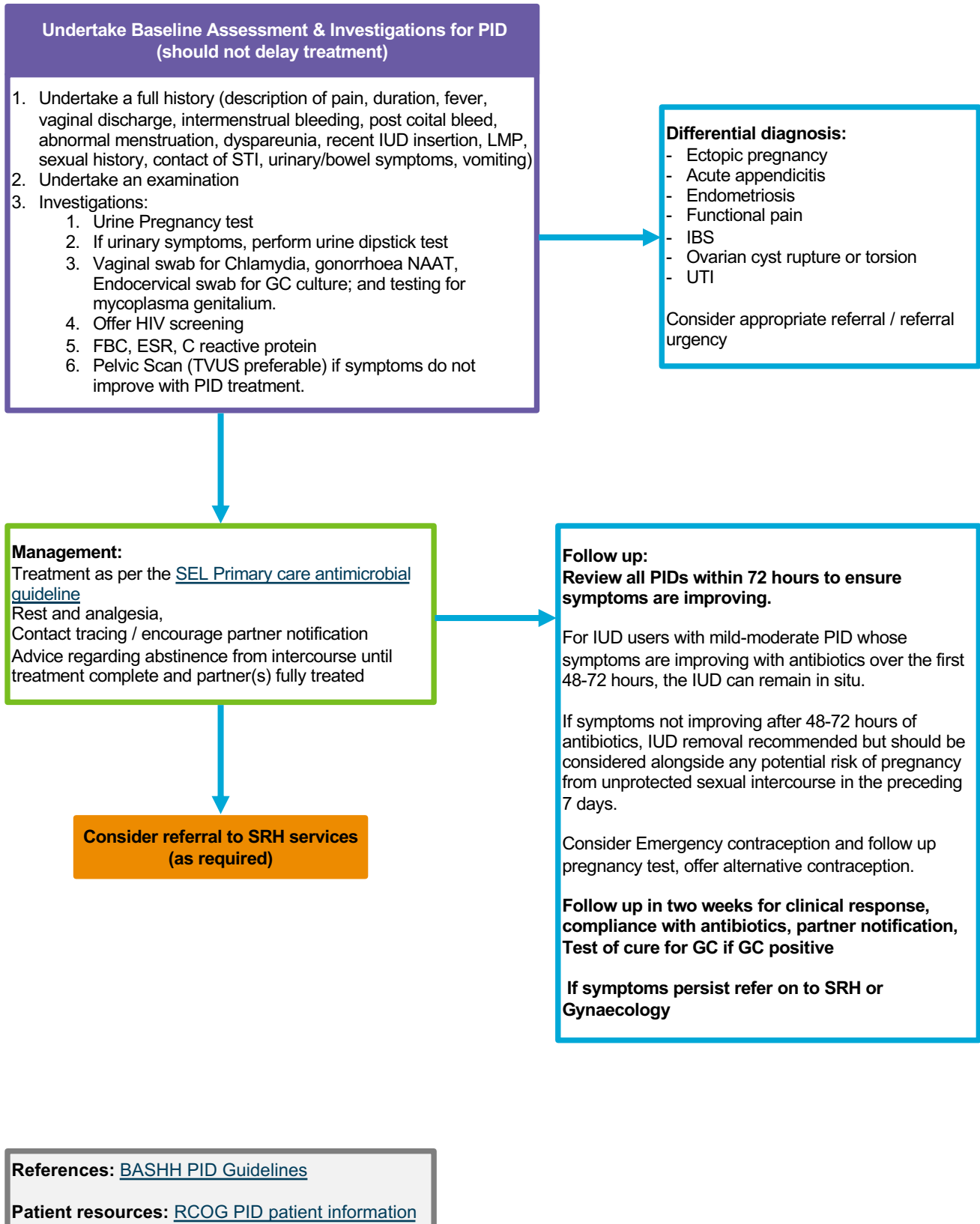
[NICE POI Guidelines](#)
[BMS POI Recommendations](#)
[ESHRE guidance 2024](#)

Patient resources:

[NICE POI patient information](#)
[Daisy Network: What is POI?](#)

22. Management of Pelvic Inflammatory Disease

NICE CKS: Pelvic inflammatory disease



Glossary

Abbreviation	Definition
2WW	Two-week wait
BD	Twice a day
Ca	Cancer antigen
CBT	Cognitive behavioural therapy
COCP	Combined Oral Contraceptive Pill
E2	Oestrogen
ERPC	Evacuation of Retained Products of Conception
GC	Gonococcus
FBC	Full blood count
FSH	Follicle-stimulating hormone
FU	Follow up
HbA1c	Haemoglobin A1c
HMB	Heavy menstrual bleeding
HVS	High vaginal swabs
IBS	Irritable bowel syndrome
IMB	Inter-menstrual bleeding
IU	Intrauterine
IUD	Intrauterine Contraceptive Device
Mcg	Micrograms
MGen	Mycoplasma Genitalia
MMR vaccine	Measles, Mumps, and Rubella vaccine
NAAT	Nucleic Acid Amplification Tests
NSAID	Non-steroidal anti-inflammatory drugs

Glossary (cont.)

Abbreviation	Definition
Od/ od	Once daily
OP	Outpatient
Os/ os	Cervical Os or opening
PCB	Post-coital bleeding
PCOS	Polycystic Ovarian Syndrome
PID	Pelvic Inflammatory Disease
PMD	Premenstrual Dysphoric Disorder
PMS	Premenstrual Syndrome
POP	Progestogen-only pill
QOL	Quality of Life
SRH Services	Sexual and Reproductive Health Services
STI	Sexually transmitted infections
T4	Thyroxine Test
TPO	Thyroid peroxidase (TPO) antibodies
TSH	Thyroid-Stimulating Hormone (TSH) Test
TV	Trichomona
TVUS	Transvaginal Ultrasound [scan]
US	Ultrasound [scan]